EXHIBIT "B"

NEW YORK STATE DEPARTMENT OF HEALTH
Bureau of Early Intervention

Application for Approval of Individual Evaluators, Service Providers and Service Coordinators

NOTE: THIS APPLICATION IS FOR APPROVAL OF INDIVIDUALS ONLY
(Use Form # DOH-3736 for agencies, sole proprietorships, partnerships, corporations or state-operated facilities)

SCHEDULE 1 - GENERAL INFORMATION

A. Applicant Identification

Applicant Name		Social Security No.
Address (Number and Street)		
(City)	(County)	(Telephone) ( )
(State)	(Zip)	(Fax) ( )

I will deliver services at the address listed above ___ Yes ___ No
I will deliver services at other site(s) I operate ___ Yes ___ No
If **"Yes"**, list the site(s) below. Use additional sheets if necessary.

Address (Number & Street)			
(City)	(County)	(Zip)	(Telephone) ( )

I will deliver services in children's homes or community settings ___ Yes ___ No
(e.g., YMCAs, child care facilities, community centers)

B. Personal Qualifying Information

Registration or Certification (Enclose copy of current registration or certification with application)

1. Name of Profession	License/Certification Number
2. Granted By (State Agency or other entity)	
3. Date License/Certificate Issued	Date Registration/Certification Expires
4. Have you ever had your license suspended or revoked? ___Yes ___ No If "Yes", attach separate sheet and describe the reasons for suspension/revocation, date of reinstatement and corrective action that facilitated reinstatement.	

C. Inservice/Continuing Education

Indicate any educational program(s) attended during the previous three years focusing on early intervention for infants and toddlers, birth to age three and their families. Use additional sheets if necessary.

Name of Program Length and content Date of attendance

_____

_____

_____

_____

D. Employment History

Specify professional employment experience for the past five (5) years, including experience with infants and toddlers at risk of developmental delay or disabilities, with most recent experience listed first. A copy of a current resume is sufficient, if it contains the above listed information.

Employed From	To	Employer Name	Address	Position Held	Job Responsibility

E. Record of Legal Actions

a) Except for minor traffic violations, were you ever convicted of any criminal or other violation of the law ?

☐ Yes ☐ No

b) Are there any criminal or other charges pending against you? ☐ Yes ☐ No

If the answer to any of these questions is "Yes", complete below:

Date of Action _____

Type of Action _____

Location _____

Persons/agencies involved _____

Description of violations/charges _____

SCHEDULE 2 – SERVICE PROVISION

A. The applicant is seeking approval to provide:

1) _____ Evaluation Services (Supplemental evaluations only)

2) _____ Service Coordination Services

3) _____ Service Provision (If "Yes", check all that apply):

a) ____ Home and community based individual/collateral visits

b) ____ Facility-based individual/collateral visits*

c) ____ Parent-child group*

d) ____ Group developmental intervention*

e) ____ Family/caregiver support group*

* If site is operated by you, you must provide copy of health and safety policies and fire evacuation procedure for each site.

B. Can you provide early intervention services in languages(s) other than English? ___ Yes ___ No

If "Yes", specify language(s)_____ _____

_____ _____

SCHEDULE 3 – SERVICE CATCHMENT AREA AND POPULATION SERVED

Check all counties in which you will provide early intervention services.

Albany	_____	Putnam	_____
Allegany	_____	Rensselaer	_____
Broome	_____	Rockland	_____
Cattaraugus	_____	St. Lawrence	_____
Cayuga	_____	Saratoga	_____
Chautauqua	_____	Schenectady	_____
Chemung	_____	Schoharie	_____
Chenango	_____	Schuyler	_____
Clinton	_____	Seneca	_____
Columbia	_____	Steuben	_____
Cortland	_____	Suffolk	_____
Delaware	_____	Sullivan	_____
Dutchess	_____	Tioga	_____
Erie	_____	Tompkins	_____
Essex	_____	Ulster	_____
Franklin	_____	Warren	_____
Fulton	_____	Washington	_____
Genesee	_____	Wayne	_____
Greene	_____	Westchester	_____
Hamilton	_____	Wyoming	_____
Herkimer	_____	Yates	_____
Jefferson	_____		
Lewis	_____	New York City	
Livingston	_____	Bronx	_____
Madison	_____	Kings	_____
Monroe	_____	New York	_____
Montgomery	_____	Queens	_____
Nassau	_____	Richmond	_____
Niagara	_____		
Oneida	_____		
Onondaga	_____		
Ontario	_____		
Orange	_____		
Orleans	_____		
Oswego	_____		
Otsego	_____		

SCHEDULE 4 – QUALIFIED PERSONNEL

Indicate your availability to provide early intervention services in full-time equivalents (FTE) for your discipline(s). To calculate the full time equivalent (FTE), divide the number of hours you are available each week by 40 (e.g. 40 hours = 1 FTE, 20 hours = 0.5 FTE, 10 hours = 0.25 FTE).

Please Note: Your FTE total **cannot** exceed 1.0 (40 hours/week).

Qualified Personnel	Availability in FTE
Audiologist	
Dietitian (Registered or Certified)	
Fellows of the College of Optometrists in Vision Development (FCOVD)	
Low Vision Specialist	
Nurse Practitioner	
Registered Nurse	
Licensed Practical Nurse*	
Occupational Therapy Assistant *	
Occupational Therapist	
Orientation and Mobility Specialist	
Physical Therapy Assistant *	
Physical Therapist	
Physician	
Physician Assistant *	
Psychologist	
Social Worker	
Speech and Language Pathologist	
Special Education Teacher	
Teacher of the Blind and Partially Sighted	
Teacher of the Deaf and Hearing Impaired	
Teacher of the Speech and Hearing Handicapped	

* Licensed Practical Nurses, Occupational Therapy Assistants, Physical Therapy Assistants, and Physician Assistants may only be approved, as individuals, to provide Service Coordination Services (see Schedule 2)

SCHEDULE 5 – ASSURANCES

The applicant assures the Commissioner of Health of compliance with all regulations pursuant to Part C of the Federal Individuals With Disabilities Education Act and Title II-A of Article 25 of the Public Health Law and:

A. The applicant attests to his/her character and competence;
B. The applicant assures the maintenance of current state licensure and/or certification and demonstrated proficiency in early childhood development, e.g., previous experience in the delivery of services to infants and toddlers with developmental delay or disability;
C. The applicant assures that he/she will notify the Department within two working days of suspension, expiration, or revocation of licensure, certification or registration;
D. The applicant provides assurances of participation in in-service training or other forms of professional training and education related to the delivery of early intervention services;
E. The applicant agrees to enter into an approved Medicaid Provider Agreement and to reassign Medicaid benefits to the local county early intervention program or City of New York early intervention program;
F. The applicant provides assurances of the ability to act as a member of a multidisciplinary team, including demonstration of prior experience in collaborating with other professionals in the design and delivery of services;
G. The applicant provides assurances of the capacity to deliver services on a twelve-month basis and to provide flexibility in hours of service delivery; and,
H. The applicant assures compliance with the confidentiality requirements set forth in regulation.

CERTIFICATION

I, the undersigned, hereby certify under penalty of perjury that I am duly authorized to subscribe and submit this application and that the information contained herein and attached hereto is accurate, true and complete. I further acknowledge that the application will be processed pursuant to the provisions of Title II-A of Article 25 of the Public Health Law, and the pertinent regulations adopted thereto.

_____ _____
Signature **Date**

_____ _____
Print or Type Name **Title**

INDIVIDUAL ACKNOWLEDGMENT

STATE OF NEW YORK)

COUNTY OF) SS.:
)

On this _____day of _____20____, before me personally appeared _____

_____residing at_____
Name Street, City, State, Zip

To me known and known by me to be the person who executed the foregoing instrument.

_____
Notary Stamp

_____
Notary Public

PROVIDER AGREEMENT
BETWEEN THE NEW YORK STATE DEPARTMENT OF HEALTH
AND SERVICE PROVIDERS IN NEW YORK STATE EARLY INTERVENTION PROGRAM

Contingent upon approval by the New York State Department of Health to participate in the New York State Early Intervention Program, and the satisfactory completion of a Medicaid provider agreement and statement of reassignment for the purpose of establishing eligibility to participate in the New York State Medicaid Program under title XIX of the Social Security act, _____, hereafter called the Provider, agrees as follows to:

A. **(1) Keep any records necessary to disclose the extent of services the Provider furnishes to recipients receiving assistance under the New York State Plan for Medical Assistance;**

(2) On request, furnish the New York State Department of Health, or its designee, and the Secretary of the United States Department of Health and Human Services, and the New York State Medicaid Fraud Control Unit any information maintained under paragraph (A) (1), and any information regarding any Medicaid claims reassigned by the Provider to the local early intervention agency;

(3) Comply with the disclosure requirements specified in 42 CFR Part 455, Subpart B;

B. **Comply with Title VI of the Civil Rights Act of 1964, Section 504 of the Federal Rehabilitation Act of 1973, and all other State and Federal statutory and constitutional non-discrimination provisions which prohibit discrimination on the basis of race, color, national origin, handicap, age, sex, religion and marital status;**

C. **Abide by all applicable Federal and State laws and regulations, including the Social Security Act, New York State Social Services Law, part 42 of the Code of Federal Regulations and Title 18 of the Codes, Rules and Regulations of the State of New York; and,**

D. **Provide services in accordance with Title II-A of Article 25 of the Public Health Law and Subpart 69-4 of Title 10 of the Codes, Rules and Regulations of the State of New York (New York Early Intervention Program).**

Authorized Signature: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Telephone No.: _____ **Date Signed:** _____

STATEMENT OF REASSIGNMENT

_____

Name of Early Intervention Program/Practitioner

By this reassignment, the above-named program or practitioner of early intervention services agrees:

1. **To reassign all Medicaid reimbursement for early intervention services to the municipal early intervention agency that you contract with to provide early intervention services.**

2. **To accept as payment in full from the municipal early intervention agency the State Department of Health promulgated payment levels for covered early intervention services.**

3. **To not bill Medicaid for eligible early intervention services which are specified in a child's individualized family services plan (IFSP). These services will be directly billed to and reimbursed by the municipal early intervention agency.**

4. **To comply with all the rules and policies as described in your contract with the municipal early intervention agency.**

_____

Signature **Date**

_____

Address

_____

City **State** **Zip**

NOTE: NOTHING IN THIS STATEMENT OF REASSIGNMENT WOULD PROHIBIT A MEDICAID PROVIDER FROM CLAIMING REIMBURSEMENT FOR MEDICAID ELIGIBLE SERVICES RENDERED OUTSIDE THE SCOPE OF THE EARLY INTERVENTION PROGRAM.

INDIVIDUAL APPLICATION CHECKLIST

- ☐ A copy of current registration or certification is enclosed for all disciplines listed in Schedule 4.
- ☐ Inservice/continuing education and employment sections are completed and related to infants and toddlers with or at risk of developmental delay or disabilities (can include lectures, seminars, conferences etc.)
- ☐ If you will provide any services in a site operated by you, copies of health and safety and fire evacuation procedures are enclosed.
- ☐ Schedule 4, full time equivalents (FTE'S) is completed and FTE total is not greater than 1.0 FTE.
- ☐ All boxes are checked and all questions are answered.
- ☐ An original signature is on Certification page.
- ☐ The Individual Acknowledgment is completed and notarized.
- ☐ The STATEMENT OF REASSIGNMENT and the PROVIDER AGREEMENT forms are signed and attached to the application.

Failure to supply all needed material at time of review will automatically render the application incomplete and it will be returned.

NEW YORK STATE DEPARTMENT OF HEALTH
Bureau of Early Intervention

Application for Approval of Agencies or Incorporated Groups of Individuals as Evaluators, Service Providers and Service Coordinators

NOTE: THIS APPLICATION IS FOR APPROVAL OF AGENCIES OR GROUPS OF INCORPORATED PROFESSIONALS ONLY (Use form #DOH -3735 for individual applicants).

INSTRUCTIONS: See detailed instructions for DOH-3736.

SCHEDULE 1 - GENERAL AGENCY INFORMATION

A. Applicant Identification

Agency Name			
Tax Identification Number /____/____/ - /____/____/____/____/____/____/____/			
Agency Address (Number & Street)			
City	County	Zip	Telephone ( ) Fax Number ( )

B. Name of Service Delivery Site(s) (if different from above; use additional sheets if necessary)

Name			
Address (Number & Street)			
City	County	Zip	Telephone ( )

C. Name and Title of Contact Person for Additional Information Regarding this Application

Name			
Address (Number & Street)			
City	County	Zip	Telephone ( )

SCHEDULE 2 - OPERATOR INFORMATION

A.

Name of Operator (Chief Executive Officer/Executive Director/Other)			
Address (Number & Street)			
City	County	Zip	Telephone ( )

B. Record of Legal Actions:

1. Except for minor traffic violations, were you ever convicted of any violation of the law (e.g. criminal, civil or malpractice charges)? ❑ Yes ❑ No

2. Have you ever been involved in a hearing before an official body in relation to the operation of an agency which provides human services? ❑ Yes ❑ No

3. Are there any criminal charges pending against you? ❑ **Yes** ❑ **No**

If the answer to any of these questions is "Yes", complete below:

Date of Action: _____

Type of Action: _____

Location: _____

Persons and/or agencies involved: _____

C. **Type of Ownership:** (Check only one – copies of documentation for Individual, Corporate or Partnership must be submitted with this application)

1) ❑ Individual
2) ❑ Corporation (*Date of Incorporation*) _____/_____/_____
3) ❑ Partnership
4) ❑ State
5) ❑ County – government agency
6) ❑ Other (Specify)

D. **Class of Operator:** (Check only one)

1) ❑ Proprietary (*for-profit*)
2) ❑ Voluntary (*not-for-profit*)
3) ❑ Public

SCHEDULE 3 - AGENCY AFFILIATION

A. Is the agency currently approved by any of the following state early intervention service agencies? (Check "Yes" or "No")

		Yes	No
1)	New York State Department of Health	❑	❑
2)	State Education Department (Approved 4410 Program)	❑	❑
3)	Office of Mental Retardation and Developmental Disabilities	❑	❑
4)	Office of Mental Health	❑	❑
5)	Department of Social Services	❑	❑
6)	Office of Alcoholism and Substance Abuse Services	❑	❑

If "yes" to any of the above, specify in what capacity the agency is approved _____
(*e.g. hospital, certified home health agency, clinic, day treatment program*)

If "yes" to any of the above, provide the date of the most current site visit or program review by the agency(ies) listed above, if known.

State Agency: _____

Date of Site Visit/Program Review: _____

State Agency: _____

Date of Site Visit/Program Review: _____

B. Has the agency ever had approval revoked by any of the above state agencies? **Yes** ❑ **No** ❑
If "yes" to above, attach separate sheets providing the following information:

1) Date of action (revoking of license or certification)
2) Reason(s) for action
3) Resolution of action (include corrective action that was taken and whether approval has been reinstated)

SCHEDULE 4 - PROJECT OUTLINE

A. Services – Check the services for which your agency is seeking approval.

1) ❑ Evaluation Services (requires the availability of a licensed physician, who must be included in Schedule 5)
2) ❑ Supplemental Evaluation Services Only (Specify which type_____)
3) ❑ Service Coordination Services
4) ❑ Service Provider (If seeking approval as a service provider, check all that apply)
   a) ❑ Home and community based individual/collateral visits
   b) ❑ Facility-based individual/collateral visits (_____check if provided at agency site(s). If checked, copies of health and safety policies, including fire evacuation, must be submitted with this Application).
   c) ❑ Parent-child groups (_____ check if provided at agency site(s). If checked, copies of health and safety policies, including fire evacuation, must be submitted with this Application).
   d) ❑ Group developmental intervention (_____ check if provided at agency site(s). If checked, copies of health and safety policies, including fire evacuation, must be submitted with this Application).
   e) ❑ Family/caregiver support group

B. Languages - Indicate the languages, other than English (if any), spoken by the staff in the agency providing evaluation services, service coordination services and early intervention services.

1) Evaluation Services — Specify language(s) _____
2) Supplemental Evaluation — Specify language(s) _____
3) Service Coordination Services — Specify language(s) _____
4) Early Intervention Services — Specify language(s) _____

C. Service Catchment Area and Population Served

Check all counties for which the agency is seeking approval to provide early intervention services.

❑ Albany	❑ Jefferson	❑ Schoharie
❑ Allegany	❑ Lewis	❑ Schuyler
❑ Broome	❑ Livingston	❑ Seneca
❑ Cattaraugus	❑ Madison	❑ Steuben
❑ Cayuga	❑ Monroe	❑ Suffolk
❑ Chautauqua	❑ Montgomery	❑ Sullivan
❑ Chemung	❑ Nassau	❑ Tioga
❑ Chenango	❑ Niagara	❑ Tompkins
❑ Clinton	❑ Oneida	❑ Ulster
❑ Columbia	❑ Onondaga	❑ Warren
❑ Cortland	❑ Ontario	❑ Washington
❑ Delaware	❑ Orange	❑ Wayne
❑ Dutchess	❑ Orleans	❑ Westchester
❑ Erie	❑ Oswego	❑ Wyoming
❑ Essex	❑ Otsego	❑ Yates
❑ Franklin	❑ Putnam	New York City
❑ Fulton	❑ Rensselaer	❑ Bronx
❑ Genesee	❑ Rockland	❑ Kings
❑ Greene	❑ St. Lawrence	❑ New York
❑ Hamilton	❑ Saratoga	❑ Queens
❑ Herkimer	❑ Schenectady	❑ Richmond

D. Special Populations

Is there a specific category of infants and toddlers with disabilities to which the agency plans to provide early intervention services (e.g. sensory impairment)? **Yes** ❑ **No** ❑

If "yes", attach separate sheet(s) describing the population.

SCHEDULE 5 - QUALIFIED PERSONNEL

A. Indicate the qualified personnel that will be available, or are needed to provide evaluation services, service coordination services or early intervention services who will be either members of the agency's staff or under contract with the agency. Indicate the FTE of the qualified personnel checked for an unduplicated count of the agency's early intervention personnel. (Refer to instructions)

Qualified Personnel	Employed Directly (FTE)	Employed by Contract (FTE)	Additional Personnel Needed (FTE)
Certified Low Vision Specialist			
Certified Occupational Therapy Assistant			
Certified School Psychologist			
Certified Social Worker			
Certified Special Education Teacher			
Certified Teacher of the Blind and Partially Sighted			
Certified Teacher of the Deaf and Hearing Impaired			
Certified Teacher of the Speech and Hearing Handicapped			
Licensed Audiologist			
Licensed Occupational Therapist			
Licensed Physical Therapist			
Licensed Physician			
Licensed Psychologist			
Licensed Practical Nurse			
Licensed Speech and Language Pathologist			
Nurse Practitioner			
Orientation and Mobility Specialist			
Physical Therapy Assistant			
Physician Assistant			
Registered Dietician			
Registered Nurse			
Other professional staff (list profession and FTE)			
Other paraprofessional staff (e.g. aides, etc. List paraprofessional FTE)			

B. If qualified personnel are available through contract, attach separate sheets describing the arrangement for **each** contractor:

- name and address
- dates of contract period
- type of contract (1-year, open-ended, etc.)
- whether or not the contractor has already received state approval as an early intervention provider and, if so, from which state agency (NYS Dept. of Health, Office of Mental Retardation and Developmental Disabilities, State Education Department, or Office of Mental Health)
- whether or not the contractor will provide early intervention services using contracted individuals or agencies

SCHEDULE 6 - ASSURANCES

The applicant assures the Commissioner of Health and, if applicable, the Commissioner of Education, Commissioner of the Office of Mental Retardation and Developmental Disabilities, and the Commissioner of the Office of Mental Health, of compliance with all regulations pursuant to Part H of the Federal Individuals with Disabilities Education Act and Title II-A of Article 25 of the Public Health Law, and;

A. The applicant assures the agency is appropriately staffed with qualified personnel with state licensure or certification as appropriate, and maintains a copy of current registration or certification for those personnel;

B. The applicant agrees to enter into an approved Medicaid Provider Agreement and to reassign Medicaid benefits to the local county early intervention program or City of New York early intervention program;

C. The applicant has the capacity to deliver services on a twelve-month basis and to provide flexibility in hours of service delivery;

D. The applicant has the capacity to deliver early intervention services in natural environments, where appropriate;

E. The applicant assures that personnel have access to and participate in ongoing in-service training on best practices in the delivery of early intervention services;

F. The applicant assures that the agency is in compliance with all local fire and health safety codes, and, if providing early intervention services in a facility-based setting, the applicant assures that the agency maintains a policy for addressing health, safety and sanitation issues;

G. The applicant attests to the program operator's character and competence, including fiscal viability of the agency; and,

H. The applicant assures compliance with the confidentiality requirements as set forth in regulation.

CERTIFICATION

I, the undersigned, hereby certify under penalty of perjury, that I am duly authorized to subscribe and submit this application and that the information contained herein and attached hereto is accurate, true and complete. I further acknowledge that the application will be processed pursuant to the provisions of Title II-A of Article 25 of the Public Health Law, and the pertinent regulations adopted thereto.

_____ _____
Type/Print Name Title

_____ _____/_____/_____
Signature Date

CORPORATE ACKNOWLEDGMENT

STATE OF NEW YORK)
) SS:
COUNTY OF)

On this _____day of _____, 20____, before me personally appeared _____
(Name)

residing at, _____ to me known and known by me to be _____
(Street, City, State, Zip) *(Title)*

of _____ and the person who executed _____
(Corporation/Agency) *(The foregoing instrument)*

in the name of said _____ and __he duly acknowledged to me that __he executed the
(Corporation/Agency)

same as and for the act and deed of said _____.
(Corporation/Agency)

_____
Notary Public

PROVIDER AGREEMENT
BETWEEN THE NEW YORK STATE DEPARTMENT OF HEALTH
AND SERVICE PROVIDERS IN NEW YORK STATE EARLY INTERVENTION PROGRAM

Contingent upon approval by the New York State Department of Health to participate in the New York State Early Intervention Program, and the satisfactory completion of a Medicaid provider agreement and statement of reassignment for the purpose of establishing eligibility to participate in the New York State Medicaid Program under title XIX of the Social Security Act, _____, hereafter called the Provider, agrees as follows to:

A. (1) Keep any records necessary to disclose the extent of services the Provider furnishes to recipients receiving assistance under the New York State Plan for Medical Assistance;

(2) On request, furnish the New York State Department of Health, or its designee, and the Secretary of the United States Department of Health and Human Services, and the New York State Medicaid Fraud Control Unit any information maintained under paragraph (A) (1), and any information regarding any Medicaid claims reassigned by the Provider to the local early intervention agency;

(3) Comply with the disclosure requirements specified in 42 CFR Part 455, Subpart B;

B. Comply with Title VI of the Civil Rights Act of 1964, Section 504 of the Federal Rehabilitation Act of 1973, and all other State and Federal statutory and constitutional non-discrimination provisions which prohibit discrimination on the basis of race, color, national origin, handicap, age, sex, religion and marital status;

C. Abide by all applicable Federal and State laws and regulations, including the Social Security Act, the New York State Social Services Law, Part 42 of the Code of Federal Regulations and Title 18 of the Codes Rules and Regulations of the State of New York; and,

D. Provide services in accordance with Title II-A of Article 25 of the Public Health Law and Subpart 69-4 of Title 10 of the Codes Rules and Regulations of the State of New York (New York Early Intervention Program).

Authorized Signature: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone No.: _____ *Date Signed:* _____/_____/_____

STATEMENT OF REASSIGNMENT

_____
Name of Early Intervention Program/Practitioner

By this reassignment, the above-named program or practitioner of early intervention services agrees:

1. To reassign all Medicaid reimbursement for early intervention services to the municipal early intervention agency that you contract with to provide early intervention services.

2. To accept as payment in full from the municipal early intervention agency the State Department of Health promulgated payment levels for covered early intervention services.

3. To not bill Medicaid for eligible early intervention services which are specified in a child's individualized family services plan (IFSP). These services will be directly billed to and reimbursed by the municipal early intervention agency.

4. To comply with all the rules and policies as described in your contract with the municipal early intervention agency.

_____ _____/_____/_____
Signature Date

_____
Street Address

_____ _____ _____
City State Zip

NOTE: NOTHING IN THIS STATEMENT OF REASSIGNMENT WOULD PROHIBIT A MEDICAID PROVIDER FROM CLAIMING REIMBURSEMENT FOR MEDICAID ELIGIBLE SERVICES RENDERED OUTSIDE THE SCOPE OF THE EARLY INTERVENTION PROGRAM.

AGENCY CHECKLIST

- ❑ Tax Identification Number (Schedule 1) must appear on application.
- ❑ Contact person (Schedule 1) must be located at the main agency site.
- ❑ Copies of all organizational documents, such as partnership agreements or certificates of incorporation, and filing receipts (Schedule 2) must be enclosed with this application.
- ❑ If you are seeking to provide facility-based services (Schedule 4) copies of health, safety and fire evacuation policies must be enclosed. Facility-based means services are being performed in a place you own, rent or lease.
- ❑ If "CORE" Evaluation Services (Schedule 4) is checked, a letter from a licensed physician on their letterhead and the FTE (availability) must be enclosed.
- ❑ Verify that ALL counties (Schedule 4) checked for which the agency is seeking approval to provide early intervention services are within an appropriate geographical area.
- ❑ Verify that ALL Qualified Personnel (Schedule 5) employed through "contract" have current state approval to provide early intervention services. Provide a list of all contracted employees including their name, address, social security number, and FTE's.
- ❑ Complete and notarize the Corporate Acknowledgment (Schedule 6 of the application).
- ❑ Statement of Reassignment and Provider Agreement Form must be signed, dated and returned with this application.

Failure to supply all needed material at time of review will automatically render application incomplete and will be returned for compliance.

EXHIBIT "C"

.ee, Sue

From: SCOTT F WALLINGFORD [wallingfordj@msn.com]
Sent: Thursday, February 08, 2007 2:17 PM
To: Lee, Sue
Subject: RE: preschool provision

Dear Sue:

This letter is in response to your e-mail regarding continuing to be listed as a preschool provider. Unfortunately, I provide speech therapy services on a part-time basis. When I initially received my contract from Orange County I had them list me as both an Early Intervention and Preschool provider with the intent that once my children were both school aged that I would begin to increase my present caseload and take on some preschoolers in the afternoons. I've even considered opening my own office space for preschool services. However, at this time, I do not have the time for this commitment. I provide services on a part-time basis and it has been just enough to keep up with the Early Intervention paperwork than take on a different entity of preschool services. So at this time, if need be, you can remove me from the preschool provider list. I hope to assist with providing preschool services in a few years when my daughter begins school full-time. Thank you for your time and assistance.

Sincerely,

Jennifer Wallingford, MS, CCC-SLP

EXHIBIT "D"

April 2004

Name
Address
Address

Re: EI/PSE contract

Dear **personal name:**

Over the past several years, Dutchess County has pursed a policy of contracting with *agencies* in order to improve the supervision and coordination of EI and PSE services in our community. In keeping with this policy we will be eliminating the remaining individual contracts when they expire on August 31, 2004

I recognize your special expertise in serving young children with disabilities and the fine services that you have offered in the past. If you would like to continue working with the birth-5 age group in Dutchess County, you may consider affiliating with one of the agencies that contract with us. I've attached the names of the primary agencies we work with for your reference.

Most of the children of the providers affected by this policy will age-out on or before the end of the current contract period. If there are children on your caseload who will continue in EI or PSE services after that date, please inform me by August 1, 2004 if you will be working with an agency so that we can re-issue their authorizations or arrange for a new provider.

Thank you for your services to the Early Intervention and Preschool Special Education systems in Dutchess County. I look forward to our continued partnership.

Sincerely,

Beverly Allyn
EI Manager

Major Agencies that contract with Dutchess County EI/PSE

Multidisciplinary Agencies

Altogether Children's Services	Diane Morrison	227-3240
Astor Early Childhood Programs	Nancy Donnelly	452-4167
Bright Beginnings Family Services	Rita Senor	485-0086
Carriage House Nursery	Kathleen Phillips	462-6701
REHAB Programs	Joan Whitesell	452-0774
St. Francis Preschool	Margaret Slomin	431-8803
Valley Consultant Services	Abbie Schiff	247-0941

Speech Services

Hudson Valley Speech	Geri Brodsky	876-4313
Dr. Volz and Amato Speech Services	Mary Van Demark	247-0668
St. Francis Communication Disorders	Bonnie Greenspan	431-8800

Physical Therapy

Center for Physical Therapy	Lynn Campili	297-4789

Counseling

Greystone Programs	Annette Heslin	452-9234 x103